

Schedule of Benefits

Employer: **Buckeye Ohio Risk Management Association Pool, Inc. (BORMA)**

MSA: 737409

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 Schedule: 2A
 Booklet Base: 2

For: Choice POS II - City of Bowling Green

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$500	\$1,000
Family Deductible*	\$1,000	\$2,000

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes plan **deductible** and **copayments**.

Plan Maximum Out of Pocket Limit excludes **precertification** penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: \$1,700.
- For **out-of-network** expenses: \$2,500.

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$3,400.
- For **out-of-network** expenses: \$6,500.

Lifetime Maximum Benefit per person	Unlimited	Unlimited
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Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams		
Office Visits	100% per visit No copay or deductible applies.	100% per visit No Calendar Year deductible applies.
<i>Covered Persons through age 21: Maximum Age & Visit Limits</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>
<i>Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months</i>	1 visit	1 visit
<i>Covered Persons age 65 and over: Maximum Visits per 12 consecutive months</i>	1 visit	1 visit
Preventive Care Immunizations		
<i>Performed in a facility or physician's office</i>	100% per visit No copay or deductible applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>	100% per visit No Calendar Year deductible applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>

Screening & Counseling Services	100% per visit No copay or deductible applies.	100% per visits
Office Visits		No Calendar Year deductible applies.
<i>Obesity and/or Healthy Diet</i>		
<i>Misuse of Alcohol and/or Drugs & Use of Tobacco Products</i>		
<i>Sexually Transmitted Infections</i>		
<i>Genetic Risk for Breast and Ovarian Cancer</i>		

<i>Obesity and/or Healthy Diet</i>		
Maximum Visits per 12 consecutive months <i>(This maximum applies only to Covered Persons ages 22 & older.)</i>	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

<i>Misuse of Alcohol and/or Drugs</i>		
Maximum Visits per 12 consecutive months	5 visits*	5 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

<i>Use of Tobacco Products</i>		
Maximum Visits per 12 consecutive months	8 visits*	8 visits*
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		

<i>Sexually Transmitted Infections Benefit Maximums</i>		
Maximum Visits per Calendar Year	2 visits*	2 visits*
*Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.		

<i>Well Woman Preventive Visits Office Visits</i>	100% per visit	100% per visit
Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	No Calendar Year deductible applies.	No Calendar Year deductible applies.
<i>Well Woman Preventive Visits Maximum Visits per Calendar Year</i>	1 visit	1 visit
<i>Routine Cancer Screening Outpatient</i>	100% per visit	100% per visit
	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Maximums	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and the comprehensive guidelines supported by the Health Resources and Services Administration. <p><i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i></p>	<p>Subject to any age; family history and frequency guidelines as set forth in the most current:</p> <ul style="list-style-type: none"> evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and the comprehensive guidelines supported by the Health Resources and Services Administration. <p><i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i></p>
<i>Endoscopic Surgery & Diagnostic Endoscopic Services (including Colonoscopy, Colonoscopy through Stoma, and Enteroscopy)</i>	100% per visit	100% per visit
	No Calendar Year deductible applies.	No Calendar Year deductible applies.
<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	One screening every 12 months*
<i>*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.</i>		
<i>Prenatal Care Office Visits</i>	100% per visit	100% per visit
	No copay or deductible applies.	No Calendar Year deductible applies.

Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.

Comprehensive Lactation Support and Counseling Services

Lactation Counseling Services <i>Facility or Office Visits</i>	100% per visit	100% per visit
	No copay or deductible applies.	No Calendar Year deductible applies.

Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	Not Applicable
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***Important Note:** Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Breast Pumps & Supplies	100% per item	100% per item
	No copay or deductible applies	No Calendar Year deductible applies

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.

Family Planning Services

Female Contraceptive Counseling Services -Office Visits	100% per visit.	100% per visit
	No copay or deductible applies.	No Calendar Year deductible applies.

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Applicable
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***Important Note:** Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Family Planning Services - Female Contraceptives

Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visits.	100% per item.	100% per item
	No copay or deductible applies.	No Calendar Year deductible applies.

Family Planning - Other

Voluntary Termination of Pregnancy Outpatient	80% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Voluntary Sterilization for Males Outpatient	80% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Family Planning - Female Voluntary Sterilization		
Inpatient	100% per visit	70% per visit after Calendar Year deductible
	No copay or deductible applies.	
Outpatient	100% per visit	70% per visit after Calendar Year deductible
	No copay or deductible applies.	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Physician Services		
Office Visits to Primary Care Physician	\$25 visit copay then the plan pays 100%	70% per visit after Calendar Year deductible
Office visits (non-surgical) to non-specialist	No Calendar Year deductible applies.	

Specialist Office Visits	\$40 visit copay then the plan pays 100%	70% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	

Physician Office Visits-Surgery	80% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible
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Walk-In Clinic Visit (Non-Emergency) Preventive Care Services*		
Immunizations	100% per visit	100% per visit
	No copay or deductible applies.	No Calendar Year deductible applies.
	For details, contact your physician , log onto the Aetna website www.aetna.com , or call the number on the back of your ID card.	
Individual Screening and Counseling Services for Tobacco Use	100% per visit	100% per visit
	No copay or deductible applies.	No Calendar Year deductible applies.
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
Individual Screening and Counseling Services for Obesity	100% per visit	100% per visit
	No copay or deductible applies.	No Calendar Year deductible applies.

Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services
<p>*Important Note: Not all preventive care services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your physician.</p>		
<i>All Other Services</i>	\$25 visit copay then the plan pays 100% No Calendar Year deductible applies.	70% per visit after Calendar Year deductible
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	80% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>	80% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
<i>Allergy Testing and Treatment</i>	80% per visit after Calendar Year deductible .	70% per visit after Calendar Year deductible .
<i>Allergy Injections</i>	80% per visit after Calendar Year deductible .	70% per visit after Calendar Year deductible .
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Emergency Medical Services</i>		
<i>Hospital Emergency Facility and Physician</i>	\$150 copay per visit then the plan pays 100% No Calendar Year deductible applies.	Paid the same as the Network level of benefits. See Important Note Below
<p>Important Note: Please note that as these providers are not network providers and do not have a contract with Aetna, the provider may not accept payment of your cost share (your deductible and payment percentage), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>		

<i>Non-Emergency Care in a Hospital Emergency Room</i>	\$150 copay per visit then the plan pays 100%	70% after Calendar Year deductible
	No Calendar Year deductible applies	

Important Notice:

A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

<i>Urgent Care Services</i>		
<i>Urgent Medical Care (at a non-hospital free standing facility)</i>	\$40 copay per visit then the plan pays 100%	70% per visit after Calendar Year deductible
	No Calendar Year deductible applies.	

<i>Urgent Medical Care (from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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Important Notice:

A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Diagnostic and Preoperative Testing</i>		
<i>Complex Imaging Services</i>		
<i>Complex Imaging</i>	80% per test after Calendar Year deductible	70% per test after Calendar Year deductible
<i>Diagnostic Laboratory Testing</i>		
<i>Diagnostic Laboratory Testing</i>	80% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
<i>Diagnostic X-Rays (except Complex Imaging Services)</i>		
<i>Diagnostic X-Rays</i>	80% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgery</i>		
<i>Outpatient Surgery</i>	80% per visit/surgical procedure after Calendar Year deductible	70% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Facility Expenses</i>		
<i>Birthing Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

<i>Hospital Facility Expenses</i> Room and Board (excluding maternity)	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Newborn Inpatient Hospital Expenses (including maternity)	100% per admission No copay or deductible applies	70% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	120 days	120 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>		
<i>Home Health Care (Outpatient)</i>	80% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible

Maximum Visits per Calendar Year	60 visits	60 visits
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<i>Skilled Nursing Care (Outpatient)</i>	80% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
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<i>Private Duty Nursing (Outpatient)</i>	80% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
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Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Hospice Care - Other Expenses during a stay	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Maximum Benefit per lifetime	180 days	180 days
Hospice Outpatient Visits		
	80% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
Maximum Benefit per lifetime	180 days	180 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		

MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Inpatient Residential Treatment Facility Expenses	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Inpatient Residential Treatment Facility Expenses Physician Services	80% after Calendar Year deductible	70% after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

Outpatient Services	\$25 per visit copay then the plan pays 100%	70% per visit after the Calendar Year deductible
	No Calendar Year deductible applies	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Inpatient Treatment of Substance Abuse

Hospital Facility Expenses

Room and Board	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

<i>Inpatient Residential Treatment Facility Expenses</i>	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
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<i>Inpatient Residential Treatment Facility Expenses Physician Services</i>	80% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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Outpatient Treatment of Substance Abuse

Outpatient Treatment	\$25 per visit copay then the plan pays 100%	70% per visit after Calendar Year deductible
	No Calendar Year deductible applies	

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
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Transplant Services Facility and Non-Facility Expenses

<i>Transplant Facility Expenses</i>	80% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Transplant Physician Services</i> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		
<i>Ground, Air or Water Ambulance</i>	80% after Calendar Year deductible	70% after Calendar Year deductible
<i>Durable Medical and Surgical Equipment</i>	80% per item after the Calendar Year deductible	70% per item after the Calendar Year deductible
<i>Insulin Pumps and Insulin Pump Supplies</i>		
	100% per supply	70% per supply after the Calendar Year deductible
	No copay or deductible applies.	
<i>Clinical Trial Therapies</i> (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Routine Patient Costs</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Prosthetic Devices</i>	80% per item after Calendar Year deductible	70% per item after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		
<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical and Occupational Therapy only</i>	80% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Speech Therapy only</i>	80% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>		
	80% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Preferred Generic Prescription Drugs</i>		
For each initial 30 day supply filled at a retail pharmacy	\$10	\$10
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	\$20	Not Applicable

<i>Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply (retail)	\$30	\$30
For more than a 30 day supply but less than a 91 day supply (mail order)	\$60	Not Applicable

<i>Non-Preferred Generic Prescription Drugs</i>		
For each 30 day supply (retail)	\$10	\$10
For more than a 30 day supply but less than a 91 day supply (mail order)	\$20	Not Applicable

Non-Preferred Brand-Name Prescription Drugs

For each initial 30 day supply filled at a retail pharmacy	\$50	\$50
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	\$100	Not Applicable

Diabetic supplies

For each 30 day supply filled at a retail pharmacy	\$0	\$0
For all fills of at least a 31 day supply and up to a 90 day supply filled at a mail order pharmacy	\$0	Not Applicable

If a **prescriber** prescribes a covered **brand-name prescription drug** where a **generic prescription drug** equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost sharing for the **brand-name prescription drug**. If you request a covered brand-name **prescription drug** where a **generic prescription drug** equivalent is available you will be responsible for the cost difference between the **brand-name prescription drug** and the **generic prescription drug** equivalent, plus the applicable cost sharing.

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to risk-reducing breast cancer generic **prescription drugs** when obtained at a **network pharmacy**. This means that such risk-reducing breast cancer generic **prescription drugs** will be paid at 100%.

Deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The **prescription drug deductible** and the per **prescription copayment/coinsurance** will not apply to the first two 90-day treatment regimens for tobacco cessation **prescription drugs** and OTC drugs when obtained at a **network pharmacy**. This means that such **prescription drugs** and OTC drugs will be paid at 100%. Your **prescription drug deductible** and any **prescription copayment/coinsurance** will apply after those two regimens have been exhausted.

Waiver for Prescription Drug Contraceptives

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** will not apply to contraceptive methods that are:

- **generic prescription drugs**; contraceptive devices; or
- FDA-approved female generic emergency contraceptives,

when obtained at a **network pharmacy**. This means that such contraceptive methods will be paid at 100%.

Refer to the *Pharmacy Plan Features* for information on coverage for FDA-Approved female over-the-counter contraceptives (Non-Emergency).

The per **prescription copay/deductible** and any **prescription drug** Calendar Year **deductible** continue to apply:

- When the contraceptive methods listed above are obtained at an out-of-network pharmacy
- For contraceptive methods that are:
 - **brand-name prescription drugs** and devices and
 - FDA-approved female brand-name emergency contraceptives,

that have a generic equivalent, or generic alternative available within the same **therapeutic drug class** obtained at an **out-of-network pharmacy** or **network pharmacy** unless you are granted a medical exception.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
FDA-Approved Female Generic Over-the-Counter Contraceptives For each 30 day supply filled at a retail pharmacy	100% per supply No copay or deductible applies.	Not covered.
FDA-Approved Female Generic Emergency Over-the-Counter Contraceptives	100% per supply No copay or deductible applies.	Not covered.
Important Note: This Plan does not cover all over-the-counter (OTC) contraceptives. For a current listing, contact Member Services by logging on the Aetna website at www.aetna.com or calling the toll-free number on the back of the ID card.		

Preventive Care Drugs and Supplements

Preventive care drugs and supplements filled at a pharmacy with a prescription :	100% per item. No copay or deductible applies.	Not Covered.
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Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact your physician or Member Services by logging onto the Aetna website www.aetna.com or calling the number on the back of your ID card.

Important Note:

Refer to the Booklet and the *Preventive Care* section for a complete description of the preventive care drugs and supplements covered under this Plan and for any limitations that apply to these benefits.

Tobacco Cessation Prescription and Over-the-Counter Drugs

Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply. 100% per supply Not covered.
No **copay** or **deductible** applies.

Maximums:
Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below.

Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	100% of the recognized charge

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Prescription Drug Maximum Out-of-Pocket Limit

	NETWORK	OUT-OF-NETWORK
Prescription Drug Maximum Out-of-Pocket Limit	\$5,150 Individual \$10,300 Family	Unlimited Unlimited

Individual Prescription Drug Maximum Out-of-Pocket Limit: Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **prescription drug covered expenses**, as follows:

Prescription Drug Maximum Out-of-Pocket Limit

When your share or each of your covered dependent’s share of **prescription drug covered expenses** reach the **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of that person’s **prescription drug covered expenses** for the rest of the calendar year. The **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Family Prescription Drug Maximum Out-of-Pocket Limit. Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

Prescription Drug Maximum Out-of-Pocket Limit

When your share and your covered dependents share of **prescription drug covered expenses** combined reach the family **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of the family's **covered expenses** for the rest of the calendar year. The family **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Excluded Covered Expenses

Certain **prescription drug covered expenses** do not apply toward your individual **prescription drug** payment percentage limit and the family prescription **drug** payment percentage limit. These include:

Expenses applied toward a deductible or copay amount.

Expenses above the **recognized charge**.

Non-covered expenses.

Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Copayments and Benefit Deductible Provisions

Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

Out-of-Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **out-of-network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

The **Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the in-network **Maximum Out-of-Pocket Limit** and **covered expenses** applied to the in-network **Maximum Out-of-Pocket Limit** will be applied to satisfy the out-of-network **Maximum Out-of-Pocket Limit**.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the “Understanding Precertification” section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A reduced payment percentage of 50% will apply separately to the eligible expenses incurred for each type of service or supply.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.